Spouse Life Insurance Enrollment Form

INSTRUCTIONS: Top box to be completed by the Employer/Plan Sponsor. Remainder to be completed by the Applicant.

Name of Employer/Plan Sponsor City of Tempe		Group/Plan Number 36063-5	Account Number/Location
State of Employee's Primary Worksite:	Employee's Date of Hire	Employee's Employment Status:	☐ Active Full-Time ☐ Active Part-Time
This change is due to: (check all that apply) ___ Initial Eligibility Following Employee's Hire	___Change in Coverage Amount ___Add Dependent Coverage	___Late Entrant* ___Other: _____	Effective Date of Coverage or Change:

**A late entrant is an individual who is first enrolling for coverage after the first available opportunity.*

Employee Information (required)

Employee Name *(last, first, middle initial)*	☐ Female ☐ Male	Date of Birth / /	Social Security #	Employee I.D. #
Employee Address *(street address, city, state, zip code)*			Telephone Work ( ) Home ( )	

Spouse Information

Name *(last, first, middle initial)*	☐ Female ☐ Male	Date of Birth / /	Social Security #
Address *(street address, city, state, zip code)*		Telephone Work ( ) Home ( )	
Have you used tobacco products of any kind in the last 12 months?		☐ Yes ☐ No	

Spouse Coverage (Minimum amount available is $20,000; maximum amount available is $500,000)

Portable Life	Total Portable Life coverage up to $500,000 is available if you complete a Portable Proof of Good Health form and ReliaStar Life approves it.
Portable Life Election	I currently have Portable Life coverage of: $_____. I am applying for additional Portable Life coverage of: $_____. *($10,000 increments)* Total Portable Life coverage (current plus additional): $_____.

Beneficiary Information *Designate your beneficiary(ies) below.*

Name of Beneficiary *(last name, first, middle initial)*	Relationship to Applicant	Benefit % *(MUST total 100%)*

Dependent Coverage

Dependent Life Insurance	Either you or the employee may cover your dependent child(ren), but not both. When you are initially eligible for dependent coverage, you can elect it without proof of good health. At all other times, a Portable Proof of Good Health form must be completed for your child(ren) and ReliaStar Life must approve it.
Dependent Life Insurance Election	☐ $5,000 for each eligible dependent child. ($500 for children age 14 days to 6 months of age) ☐ $10,000 for each eligible dependent child. ($1,000 for children age 14 days to 6 months of age) ☐ Waive

Note: The covered parent is the beneficiary for any dependent child(ren) insurance coverage.

(SEE OTHER SIDE)

READ THIS INFORMATION CAREFULLY AND THEN SIGN AND DATE BELOW

- Employee: I authorize my employer to deduct from my wages the premium, if any, for the elected coverage.
- To the best of my knowledge and belief, the information I have provided on this form is correct.
- I understand that any person who knowingly and with intent to defraud, submits an application or files a claim containing any materially false or misleading information, commits a fraudulent act, which is a crime.
- I understand my coverage begins on the effective date assigned by ReliaStar Life, provided the employee is actively at work.
- I also understand that evidence of insurability may be required for coverage to become effective.

Employee's Signature (required)	Date Signed / /
Spouse's Signature	Date Signed / /

FOR EMPLOYER/PLAN SPONSOR USE ONLY

COVERAGE	LIFE	CHILD LIFE
ACCOUNT		
CLASS		
AMOUNT		
EFF. DATE		